

Northwest Sinus Center

Director: Ryan P. Gallivan, MD

central oregon

EAR | NOSE | THROAT

New Patient Questionnaire

Name	MRN	DOB	Date
Telephone H	W	M	
Pharmacy Name	Telephone		
How did you hear about us? <input type="checkbox"/> Sent by another physician (If so, please give name below.) <input type="checkbox"/> Sent by a friend <input type="checkbox"/> Internet search <input type="checkbox"/> Other (Specify)			
Physician #1 (<input type="checkbox"/> sent by this physician)			
Name	Fax	Telephone	
Address	City, State	Zip	
Physician #2 (<input type="checkbox"/> sent by this physician)			
Name	Fax	Telephone	
Address	City, State	Zip	

Important Note on Medical Records and Previous Imaging

Please be sure to bring your previous medical records. In particular, previous CT scans and MRI scans of the nose and sinuses are very important. Please try to obtain the actual films (not just the radiology reports).

START HERE:

What symptom gives you the most trouble?

Nasal Symptom Inventory

The following rating scale will be used to complete the questions:

Scale	Severity Definition
0	None Absent-NO symptom evident
1	Mild Symptom clearly PRESENT but minimal awareness; easily tolerated
2	Moderate Definite awareness of symptom that is bothersome, but tolerable
3	Severe Symptom is hard to tolerate; interferes with activities of daily living and/or sleeping

Using the rating scale above, please rate the following symptoms according to how you feel right now.

	None	Mild	Moderate	Severe
Facial or sinus pressure (pressure or fullness in the area behind the eyes, cheeks, forehead, or sinuses)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Facial or sinus pain (pain in the area around the eyes, cheeks, forehead)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headache (dull to intense, throbbing pain in head)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nasal congestion (stopped up or stuffy nose)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nasal obstruction (inability to move air through the nose)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Post-nasal drip (sinus drainage in the back of the throat)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clear nasal discharge (nasal mucus that is clear)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Discolored nasal discharge (nasal mucus that is green, yellow, and/or brown)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Itchy nose/eyes/throat (sensation of itchiness in the nose, eyes and/or throat)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nose bleeds (bleeding, not bloody mucus, from the nose)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tiredness (feeling worn out or drained due to chronic sinusitis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing (whistling sound from breathing, associated with chest tightness)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Sino-Nasal Outcome Test (SNOT-22)

Below you will find a list of symptoms and social/emotional consequences of your rhinosinusitis. We would like to know more about these problems and would appreciate your answering the following questions to the best of your ability. There are no right or wrong answers, and only you can provide us with this information. Please rate your problems as they have been over the past two weeks. Thank you for your participation. Do not hesitate to ask for assistance if necessary.

Important: Please mark the most important items affecting your health (maximum of 5 items).

Considering how severe the problem is when you experience it and how frequently it happens, please rate each item below on how "bad" it is by circling the number that corresponds with how you feel using this scale:

	No Problem	Very Mild Problem	Mild or Slight Problem	Moderate Problem	Severe Problem	Problem as Bad as It Can Be	Most Important Items
1. Need to blow nose	0	1	2	3	4	5	<input type="radio"/>
2. Sneezing	0	1	2	3	4	5	<input type="radio"/>
3. Runny nose	0	1	2	3	4	5	<input type="radio"/>
4. Cough	0	1	2	3	4	5	<input type="radio"/>
5. Post-nasal discharge (dripping at the back of your nose)	0	1	2	3	4	5	<input type="radio"/>
6. Thick nasal discharge	0	1	2	3	4	5	<input type="radio"/>
7. Ear fullness	0	1	2	3	4	5	<input type="radio"/>
8. Dizziness	0	1	2	3	4	5	<input type="radio"/>
9. Ear pain	0	1	2	3	4	5	<input type="radio"/>
10. Facial pain/pressure	0	1	2	3	4	5	<input type="radio"/>
11. Difficulty falling asleep	0	1	2	3	4	5	<input type="radio"/>
12. Wake up at night	0	1	2	3	4	5	<input type="radio"/>
13. Lack of a good night's sleep	0	1	2	3	4	5	<input type="radio"/>
14. Wake up tired	0	1	2	3	4	5	<input type="radio"/>
15. Fatigue	0	1	2	3	4	5	<input type="radio"/>
16. Reduced productivity	0	1	2	3	4	5	<input type="radio"/>
17. Reduced concentration	0	1	2	3	4	5	<input type="radio"/>
18. Frustrated/restless/irritable	0	1	2	3	4	5	<input type="radio"/>
19. Sad	0	1	2	3	4	5	<input type="radio"/>
20. Embarrassed	0	1	2	3	4	5	<input type="radio"/>
21. Sense of taste/smell	0	1	2	3	4	5	<input type="radio"/>
22. Blockage/congestion of nose	0	1	2	3	4	5	<input type="radio"/>

Do you have RECURRENT or CHRONIC NASAL/SINUS INFECTIONS?

___ NO ___ YES ___ Yes, this is my main complaint

IF NO GO TO THE NEXT SECTION, Nasal Congestion, (Below)

To the best of your recollection, please list all the antibiotics you have taken for nasal/sinus infections: _____

Which describes the longest period of time you were on continuous, uninterrupted antibiotic therapy?

- ___ less than 10 days
- ___ 10 days to less than 2 weeks
- ___ 2 weeks to less than 1 month
- ___ 1 to 2 months
- ___ more than 2 months
- ___ can't recall

Have you used any of these other treatments? (check all that apply)

___ humidifier ___ saline nasal spray ___ air purifier
___ steam inhalation ___ other (please describe: _____)

Do you have NASAL CONGESTION or BLOCKAGE (STUFFINESS)?

___ NO ___ YES ___ Yes, this is my main complaint

IF NO GO TO THE NEXT SECTION, SMELL or TASTE disturbance (right column of this page)

Do you have this blockage/congestion now? ___ no ___ yes
Which side of your nose is most often affected? ___ right ___ left ___ both

Is the congestion/blockage worsened by:

lying down? ___ no ___ yes ___ not sure
 alcohol consumption? ___ no ___ yes ___ not sure
 tobacco smoke? ___ no ___ yes ___ not sure
 pollution? ___ no ___ yes ___ not sure
 perfumes? ___ no ___ yes ___ not sure
 other environmental irritants ___ no ___ yes ___ not sure
 (please specify) _____

Do you have a change in your sense of SMELL or TASTE?

___ NO ___ YES ___ YES, this is my main complaint

IF NO GO TO THE NEXT SECTION, Nasal Discharge, (Next Page)

Which best describes the change in your taste/smell:

___ diminished sense of taste ___ loss of taste ___ detect bad taste
 ___ diminished sense of smell ___ loss of smell ___ detect bad odor
 ___ burning tongue sensation

If you have loss of smell, does your sense of smell ever improve?

___ no ___ yes

Do you detect an odor that other people cannot? ___ no ___ yes

Please describe when you first developed these symptoms: _____

Do you have decreased or absent sense of smell today? _____

Do (es) your smell/taste symptom (s): _____ no ___ yes

worsen with sinus/nasal infection? ___ no ___ yes ___ not sure
improve with medications/treatment? ___ no ___ yes ___ not sure

Do you have NASAL DISCHARGE/DRAINAGE, POST-NASAL DRIP or RUNNY NOSE?

___ NO ___ YES ___ YES, this is my main complaint

IF NO GO TO THE NEXT SECTION, Nasal Bleeding (right column this page)

Please describe when you first developed these symptoms:

Does the drainage appear mostly after eating? ___ no ___ yes ___ not sure

Have you had your typical drainage today? ___ no ___ yes

In which direction does the drainage usually pass?

___ forward, out of my nose
___ backwards into my throat
___ both forwards and backwards

Which side of your nose is most affected?

___ right
___ left
___ both

Is the drainage usually discolored or clear?

___ discolored
___ clear
___ sometimes discolored, sometimes clear

Please check all which best describes the typical appearance(s) of your drainage:

___ clear ___ yellow ___ green ___ brown
___ opaque white ___ blood-tinged ___ black ___ orange

Is the drainage thin and water-like, or thicker like mucus?

___ thin ___ thick ___ both

If thin, does it have a salty taste?

___ no ___ yes ___ not sure

If thin, does it appear after bending, lifting, or staining?

___ no ___ yes ___ not sure

Do you have NASAL BLEEDING from your nose?

___ NO ___ YES ___ YES, this is my main complaint

IF NO GO TO THE NEXT SECTION, Facial pain/Headache (next page)

Please describe when you first developed these symptoms:

Please describe the typical amount of blood that is present.

___ occasional streaking on tissues
___ daily streaking on tissues
___ occasional blood clots
___ intermittent bouts of heaving bleeding

Have you had nasal bleeding today? ___ no ___ yes

Which side of your nose is most affected?

___ right
___ left
___ both

Do you cough up blood? ___ no ___ yes

Do you have bleeding most often in winter? ___ no ___ yes

Does your nose bleed after nose blowing? ___ no ___ yes

Does bleeding occur with nasal spray use? ___ no ___ yes

How has your nasal bleeding been treated? _____

Do you have FACIAL PAIN/PRESSURE or HEADACHE?

___ NO ___ YES ___ YES, this is my main complaint

IF NO GO TO THE NEXT SECTION, Past Medical HISTORY (page 7)

Please describe when you first developed headache/sinus pain:

On which side is your pain more prominent?

- ___ right
- ___ left
- ___ both

Where is your facial pain/headache most marked?

- ___ at the inner angle of the eye ___ in the cheeks
- ___ around the eye ___ in the back of your head
- ___ on the forehead or eyebrow ___ on your upper teeth
- ___ behind your eyes ___ on your temple
- ___ other (please describe) _____

What is the most appropriate description of this facial pain/headache?

- ___ pressure ___ fullness/heaviness
- ___ throbbing ___ sharp/stabbing
- ___ dull ache ___ cannot be described
- ___ other (please describe) _____

Do you have any facial pain/headache now? ___ no ___ yes

If yes, please rate your current discomfort

0 1 2 3 4 5 6 7 8 9 10
 no pain _____ worst pain possible

Does your facial pain/headache worsen with:

- airplane flight ___ no ___ yes ___ not sure
- (headache pain only, not ear pain)
- sinus infections ___ no ___ yes ___ not sure
- changes in weather ___ no ___ yes ___ not sure
- position of your head ___ no ___ yes ___ not sure
- certain foods ___ no ___ yes ___ not sure
- alcohol consumption ___ no ___ yes ___ not sure
- tobacco smoke ___ no ___ yes ___ not sure
- pollution ___ no ___ yes ___ not sure
- perfumes ___ no ___ yes ___ not sure
- other irritants (please specify) _____

Is your discomfort associated with:

- nausea and/or vomiting? ___ no ___ yes ___ not sure
- nasal congestion/stuffiness? ___ no ___ yes ___ not sure

Have you been diagnosed with migraine headaches, by another physician?
 ___ no ___ yes

If yes, please answer the following questions.

How have you been treated for migraines? _____

How frequently do you have migraine headaches?

- ___ daily
- ___ weekly
- ___ monthly
- ___ annually

Can you distinguish your migraine headache from sinus-related pain?

___ no ___ yes

General

How frequently do you have sinus and nasal symptoms?

- Continuously
- This is the first episode.
- 3 times/year
- 4-6 times per year
- Monthly
- Weekly
- Daily
- Constantly

Do your symptoms improve between episodes?

- Yes, they completely improve
- No, they never improve
- Sometimes, they improve
- They improve partially

How often do your baseline symptoms get worse?

- Never (The symptoms are always the same.)
- 1-3 times/year
- 4-6 times per year
- More than 6 times per year

Which best describes your sense of smell?

- No problem with sense of smell
- Diminished sense of smell
- Loss of smell
- Detect bad odor

Have you ever had a sinus CT or MRI scan?

- Yes
- No

If yes, please provide details (including dates) below.

Have you ever had a sinus or nasal surgery?

- Yes
- No

If yes, please provide details (including dates) below.

Details

Allergy Page

Do you have any of these allergy symptoms?

- Sneezing fits
- Itchy ears
- Itchy eyes
- Itchy nose
- Runny nose
- Itchy throat
- Runny/watery eyes
- Scratchy roof of your mouth

When are your allergy symptoms most apparent?

- Spring
- Summer
- Fall
- Winter
- Continuously throughout the year

Have you ever been tested for allergy?

- Never
- I have had skin testing for allergy.
- I have had blood testing for allergy.

Have you received allergy shots?

- Never
- Yes, and they helped a great deal.
- Yes, and they helped somewhat.
- Yes, and they did nothing.

Do you take aspirin or any other anti-inflammatory medication on a regular basis?

- Yes
- No

Are you allergic to aspirin or Ibuprofen products?

- Yes
- No

Asthma

Do you have asthma?

- Yes
- No

If yes, what do you take for your asthma?

- Asthma inhalers
- Nebulizer treatments
- Oral steroids
- Theophylline
- Other

Trauma

Have you ever broken your nose?

- Yes
- No

Have you ever sustained other facial and/or head injuries?

- Yes
- No

Rhinosinusitis Disability Index (RSDI)

Instructions: This 30-question survey was designed to help understand the severity of your disease and how it can affect every aspect of your daily life. For each of the following questions, please mark in the one circle that best describes your answer. If you are unsure about how to answer a question, please give the best answer you can.

		Never	Almost Never	Sometimes	Almost Always	Always
F1	Because of my problem I feel handicapped	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F2	Because of my problems I feel restricted in performance of my routine daily activities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F3	Because of my problem I restrict my recreational activities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F4	Because of my problem I feel frustrated	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F5	Because of my problem I feel fatigued	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
P6	Because of my problem I do not sleep well	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
P7	I have difficulty with exertion due to my nasal obstruction	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
P8	I am inconvenienced by my chronic runny nose	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
P9	The pain or pressure in my face makes it difficult for me to concentrate	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
P10	The pain in my eyes makes it difficult for me to read	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
P11	I have difficulty stooping over to lift objects due to face pressure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
E12	Because of my problem I feel stressed in relationships with friends and family	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
E13	Because of my problem I avoid traveling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
E14	Because of my problem I feel confused	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
E15	Because of my problem I have difficulty paying attention	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
E16	Because of my problem I avoid being around people	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
E17	Because of my problem I am frequently angry	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
E18	Because of my problem I do not like to socialize	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
E19	Because of my problem I frequently feel tense	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
P20	Food does not taste good because of my change in smell	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
E21	Because of my problem I frequently feel irritable	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
P22	Because of my problem I have difficulty with strenuous yard work and housework	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F23	Because of my problem I miss work or social activities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
P24	My frequent sniffing is irritating to my friends and family	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
P25	Straining increases or worsens my problem	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
E26	Because of my problem I am depressed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
E27	My problem places stress on my relationship with members of my family or friends	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F28	My outlook on the world is affected by my problem	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F29	Because of my problem I find it difficult to focus my attention away from my problem and on other things	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
P30	My sexual activity is affected by my problem	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Previous Treatments

Which antibiotics have you received over the past year?

- Amox and/or PCN.
- Amox/clav (Augmentin)
- Azithromycin (Zithromax, Z-pak)
- Cefadroxil (Duricef)
- Cefdinir (Omnicef)
- Cefpodoxime (Vantin)
- Cefprozil (Cefzil)
- Cefuroxime (Ceftin)
- Cephalixin (Keflex)
- Ciprofloxacin (Cipro)
- Clarithromycin (Biaxin)
- Erythromycin
- Gatifloxacin (Tequin)
- Levofloxacin (Levaquin)
- Loracarbef (Lorabid)
- Moxifloxacin (Avelox)
- SMP/TMX (Bactrim, Sulfa)
- Telithromycin.
- IV antibiotics
- Others
- Unknown
- None

Which antihistamines have you received over the past year?

- Cetirizine (Zyrtec)
- Cetirizine/decongestant (Zyrtec-D)
- Desloratadine (Clarinex)
- Desloratadine/decongestant (Clarinex-D)
- Diphenhydramine (Benadryl)
- Fexofenadine (Allegra)
- Fexofenadine/decongestant (Allegra-D)
- Levocetirizine (Zyzal)
- Loratadine (Claritin)
- Loratadine/decongestant (Claritin-D)
- Others
- Unknown
- None

Which nasal sprays have you used over the past year?

- Budesonide (Rhinocort)
- Ciclesonide (Omnaris)
- Flunisolide (Nasarel)
- Fluticasone furoate (Veramyst)
- Fluticasone propionate (Flonase)
- Mometasone (Nasonex)
- Triamcinolone (Nasacort)
- Oxymetazoline (Afrin)
- Azelastine (Astelin)
- Olopatadine (Patanase)
- Ipratropium bromide (Atrovent)
- Others
- Unknown
- None

What other treatments have you used over the past year?

- Montelukast (Singulair)
- Antifungal treatments
- Guaifenesin OTC (Mucinex)
- Nasal saline sprays
- Nasal saline irrigations
- Oral decongestants
- Systemic steroids
- Topical antibiotic irrigations/treatments
- Others
- Unknown
- None

Review of Systems

The following is a list of common symptoms and health problems. Please review the list and indicate with a check mark which symptoms and health problems that you are experiencing.

	Yes	No	Treated by another physician
General			
Nausea	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Weight gain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Weight loss	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fevers/chills	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ears, Nose & Throat			
Hoarseness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hearing loss	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Draining ear	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Vertigo	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Loud snoring	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Daytime sleepiness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mouth sores	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Tooth problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Painful/difficult swallowing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ringing in the ears	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Eyes			
Double vision	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Blurry vision	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cardiac			
Chest pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Short of breath	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Respiratory			
Wheezing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cough	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	Yes	No	Treated by another physician
Gastro-intestinal			
Heartburn	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Belly pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Diarrhea	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Constipation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Vomiting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Skin			
Rashes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ulcers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Musculo-skeletal			
Muscle pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Muscle weakness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Endocrine			
Cold intolerance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Heat intolerance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Excessive thirst	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hematologic			
Anemia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bleeding	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bruising	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Neurological			
Seizures	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Psychiatric			
Depression	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Anxiety	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Past History

Do you have any of the following medical problems?

- Arthritis
- Asthma
- Bleeding disorder
- Cataracts
- Chronic fatigue syndrome
- Depression
- Diabetes
- Fibromyalgia
- Gastritis
- Glaucoma
- Hepatitis
- High blood pressure
- Heart disease
- Immunodeficiency
- Kidney disease
- Meningitis
- Migraine headache
- Mitral valve prolapse
- Peptic ulcer disease
- Seizures
- Thyroid disease
- Tuberculosis (TB)

Please list your previous surgical procedures.

Please list your previous hospitalizations.

Do you have any other medical problems not listed above?

- Yes
 - No
- (If yes, please give details.)*

Please list your current medications.

Are you allergic to any medications?

- Yes
 - No
- (If yes, please give details.)*

Family History

Do any of your family members have any of the following conditions?

- Allergy
- Asthma
- Bleeding disorder
- Cancer
- Cystic fibrosis
- Heart disease
- Immunodeficiency

Social History

What is your occupation?

Have you had any recent change in your home or work environment? Details

- Yes
- No

Do you smoke? Details

- Yes
- No

Do you drink alcoholic beverages? Details

- Yes
- No

Have you ever used cocaine or other illicit substances? Details

- Yes
- No.